How to ensure virtual working and technology is enhanced to deliver exemplar MDTs:

1.1 All services connected to the MDT are on the same IT system and /or are able to access MDT discussion / care plan information

Why is this important?

Having all services connected via one IT system enables sharing of records and minimises duplication. Key updates can be viewed by all, building an awareness within the MDT of the interventions being offered to the supported individual.

Hints and tips:

- Review historical information-sharing agreements between services and consider proxy access for medication ordering
- Consider a shared electronic care plan if services are on the same IT system; alternatively, consider a wellbeing plan that can be shared with all members of the MDT
- Consider using Microsoft Teams to share a RAG-rated case list where MDTs do not have shared IT systems. The MDT Care Co-ordinator will need to relay key updates on the care plan to relevant MDT members.

Dorset approach example of shared IT system:

All community services use SystmOne (apart for Social Services and Community Mental Health teams). An information-sharing agreement is used to share information with patient consent. A recent pilot allowed care homes to access SystmOne, giving care homes access to the central care plan.

Hampshire approach example of partially shared IT system:

Community MDT teams have found value in a shared Health and Care Co-ordinator role. For further NHS guidance on the Care Co-ordinator role NHS England MDT Development on pages 16-17

During the Covid-19 pandemic MDTs using Microsoft Teams for MDT discussions have found that a shared RAG rated case list, shared via Teams, allowed all services to access and update one central priority case list. Although services do not share one central care plan on a shared IT system, a well-being plan for each individual is created and shared (with signed consent). All services do need access to an NHS.net email.

In order to enable ordering of repeat medications and allow care home staff to include a GP note, care homes have been given EMIS (a digital clinical system supporting joined up working across all care settings) proxy access. Further guidance can be found on the NHS England website: Ordering medication using proxy access: Guidance for care homes

How to ensure virtual working and technology is enhanced to deliver exemplar MDTs:

1.2 Electronic MDT discussion tool in use

Why is this important?

An electronic MDT discussion tool is helpful in allowing clear documentation of the reason why each patient requires an MDT discussion to ensure the right people are present to discuss the individual patient's needs. It records the outcomes during MDT discussions, and helps clarify responsibility for any actions agreed, following patient discussion. Actions can then be completed in a timely manner, by the right person.

Hints and tips:

- When using an electronic discussion tool, many MDTs have made it part of the MDT Care co-ordinator role to ensure the individual at the centre of MDT discussions is included and aware of the outcomes.
- Good discussion topics include:
  - Reason for the discussion
  - Frailty scoring and recognition of any of the frailty syndromes (falls, immobility, delirium, incontinence, susceptibility to side effects of medication)
  - Cognition
  - Capacity discussions
  - Functional status (including mobility, ability to manage personal care and everyday living activities)
  - Falls risk
  - Carer support and social support
  - Skin integrity
  - Incontinence
  - Weight
  - Medication
  - Actions and outcomes (including who is responsible).

An example electronic discussion tool can be found within the Dorset Frailty toolkit p6

How to ensure virtual working and technology is enhanced to deliver exemplar MDTs:

1.3 Clear underpinning common principles documented

Why is this important?

Documenting and communicating widely the values and plans of the MDT ensures common understanding across different agencies, builds trust and understanding, and gives the MDT a common purpose. An MDT Care co-ordinator role is invaluable in documenting and communicating the plans of the MDT. More information about the role and responsibility of the MDT Care co-ordinator can be found Section 3.2 Care co-ordinator role.

Hints and tips:

- Part of the MDT co-ordinator role within many MDTs is to ensure the individual at the centre of MDT discussions is included and aware of outcomes of the MDT discussion
- Use NHS England guidance to help you define your common principles **NHS England MDT development common principles PG 27-28**

How to ensure virtual working and technology is enhanced to deliver exemplar MDTs:

1.4 Process chart from risk profiling patients for MDT discussion to MDT outcomes is followed with management support

Why is this important?

Management support for clinical and administrative staff, documented in a clear process chart showing the integration of MDT meetings into the existing work of staff assigned to the MDT, helps allocate time and role responsibility to the MDT process and will ensure both smooth and efficient working of the MDT.

A process chart helps ensure efficient and effective meetings based on a clear plan that shows responsibility of:

- The risk profiling team prior to the meeting
- The MDT co-ordinator and link workers prior to meeting
- A named GP for any preparatory work prior to meeting

Hints and tips:

- The Dorset Frailty Toolkit has an example of a process chart

Example MDT process chart Dorset Frailty Toolkit p3

How to ensure virtual working and technology is enhanced to deliver exemplar MDTs:

1.5 + 1.6 Process and outcome measures used to achieve intended outcome

Why is this important?

Process and outcome measures enable services to understand whether they are achieving the desired outcome of reducing unplanned hospital admissions for those over 65 living with moderate or severe frailty in the community.

Hints and tips:

- Identify measures that will be used to evaluate the effectiveness of your service prior to starting service delivery, considering all organisations contributing to the MDT work
- Identify an analyst within your organisation who can help create and run reports
- Outcome measures can be collected by running reports on the GP system or from daily acute admission rates in secondary care

Example Process and Outcome measures Dorset Frailty Toolkit p22

How to ensure virtual working and technology is enhanced to deliver exemplar MDTs:

1.7 Access to frailty E-Learning training modules for all those involved in MDT discussions

Why is this important?

As frailty services resume service provision after being disrupted during the Covid-19 pandemic 2020/ 2021 many have highlighted frailty training for new MDTs and restored MDTs as a priority, to ensure frailty best practice principles become 'everyone's business.'

Hints and tips:

- Consult virtual MDT staff to understand and identify their training and resource needs
- Utilise virtual training resources available

Resources available:

Wessex Academic Health Science Network (AHSN) and Hampshire Hospitals Foundation Trust (HHFT), in collaboration with the London Clinical Frailty Network, Imperial College Healthcare NHS Trust and Health Education England, launched *Frailty, E-Learning for Excellence in Frailty Identification, Assessment and Personalised Care* on 31 March 2021

- **Access Tier 1 and Tier 2 training at: https://portal.e-lfh.org.uk/Component/Details/683810, or via Frailty - e-Learning for Healthcare (e-lfh.org.uk)**
- **Access Tier 3 training https://www.bgs.org.uk/resources/frailty-hub-education-and-training**

How to share MDT information with other health and social care organisations

2.1 One shared electronic care plan is used

Why is this important?

"Successful information sharing is based upon a common approach across agencies. Ideally, a single system that is accessible to all relevant MDT professionals and for example might include paramedics. A key mechanism to ensure information sharing is good IT support to manage interoperability between systems."

"It would make our lives easier if we could collaborate online with shared systems. To know if they've (patient) seen a district nurse in the last few days or know about a GP's decision would be really helpful"[1]

One shared electronic care record allows key updates to be viewed by all, minimises duplication of records and builds an accurate understanding by all members of the MDT of the interventions the individual is being offered. It enables different health and care team members to complete different parts of the care plan (specific to their area of expertise and intervention) with the individual.

Hints and tips:

- **Core components of the care plan to consider include:**
  - Indicate professionals involved, admission avoidance care and reviews
  - Carers and relationship details
  - Summaries of functional ability (ability of individual to manage self-care) recording patient and or carer view alongside health professional's summary
  - Admission avoidance care plan – includes clinical escalation plan, self-management plan and preferred place of care
  - Optional - decisions in relation to resuscitation decisions and advanced directives, palliative care and anticipatory care decisions, dementia care plan, additional guidance and forms
  - Problems / medication list
  - Consent to share information
- The Dorset Frailty toolkit has an example of a shared electronic care plan

Case Example: Dorset Care Plan Dorset Frailty Toolkit p14-20

[1] https://wessexahsn.org.uk/img/projects/Synthesis%20of%20Insight%20Reports_MDT%202021_2.pdf

How to ensure both the patient, their family/carers are included in MDT discussions

3.1 All documentation tools (Care plan / MDT discussion/ wholistic comprehensive assessment) clearly record patient/ carers perspective and priorities

Why is this important?

Ensuring all documentation clearly indicates and shows understanding of patient/ carer perspective and priorities helps prompt the MDT to return to the individual at the centre of the care plan and wrap decisions and interventions (including non- medical and how an individual's health is described) around the individual and their carers.

"Patients and carers expressed both benefits e.g. they did not need to duplicate their history across agencies and concerns e.g. not receiving continuity of care from one healthcare professional."[2] Ensure patient views and concerns are considered and facilitated where possible.

Hints and tips:

- Record the choice of an individual whether their wish is to receive all treatments at prolonging life regardless of outcome or for a priority of comfort and quality of life, a suggested statement below:

> "Bob feels that although he does get severe chest infections at times, his quality of life is good in between these, and he is still able to do most of the things he wants to do. If he becomes severely unwell, he would want admission to hospital for any intensive treatment aimed at prolonging his life."

Part of the MDT co-ordinator role within many MDTs is to ensure the individual at the centre of MDT discussions is included and aware of the outcomes.

Example of the MDT care co-ordinator role and function:

Care Co-ordinator role and function NHS England MDT Development p16

[2] [2] https://wessexahsn.org.uk/img/projects/Synthesis%20of%20Insight%20Reports_MDT%202021_2.pdf

How to ensure both the patient, their family/carers are included in MDT discussions

3.2 Care co-ordinator role has been developed, with part of the role to ensure family/ carers are included in MDT discussions

Why is this important?

A Care Co-ordinator has been recorded as a key component in smooth and efficient running of the MDT.

"Research demonstrates that the most successful examples of integrated care and the facilitation of multi-disciplinary teams have been those that identified a designated care co-ordinator/ case manager."[3]

Hints and tips:

- For further guidance on the function of the Care Co-ordinator, review p16-17 **NHS England MDT Development**

How to standardise who attends MDT sessions, including identifying key representatives from health, social care, and voluntary care

4.1 Terms of reference for the MDT are documented

Why is this important?

"Key agencies are required to assign a range of professionals to MDTs to ensure their success."[4]
Terms of reference ensure clarity about how the MDT will run and who it includes.

Hints and tips:

- Ensure you include:
  - Purpose of your MDT
  - Attendance
  - Expectation of the chairperson and attendees
  - How records will be kept and your processes

Example of a terms of refence document Dorset Frailty Toolkit p4-5

How to standardise who attends MDT sessions, including identifying key representatives from health, social care, and voluntary care

4.2 Roles and responsibilities of all attending the MDT are documented and agreed

Why is this important?

Having key roles and responsibilities documented and agreed for all members for the MDT help ensure engagement and attendance at meetings, as those invited understand the part they play and expectations of them.

Hints and tips:

- Consider developing a video resource/ case study that describes the different team members of your MDT and their roles
  www.healthcareers.nhs.uk may be a helpful resource to help describe roles

Example of roles and responsibilities written into your terms of reference document
Dorset Frailty Toolkit p4-5

Example case study that shows how health and social care working together transformed the care Dennis received at the Weymouth Hub, illustrated in this short film called 'Now we have help'
https://ourdorset.nhs.uk/case-study/weymouth-hub/

[3] https://www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf

[4] https://wessexahsn.org.uk/img/projects/Synthesis%20of%20Insight%20Reports_MDT%202021_2.pdf

References:

- **Dorset Frailty Toolkit -** Intended as a practical guide to formalise the structure of the MDT process with step-by-step support
  https://clahrc-wessex.nihr.ac.uk/img/casestudies/Tool%20Kits%20JN20857.pdf

- **MDT Development - Working toward an effective multidisciplinary/multiagency team - A** handbook on multi-disciplinary teams
  https://www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf

- **NHS England House of Care – a framework for long term condition care**
  https://www.england.nhs.uk/ourwork/clinical-policy/ltc/house-of-care/

- **11 projects from the Wessex AHSN Insight team library 2016-2019 -** A report on the findings of these projects can be found here:
  https://wessexahsn.org.uk/img/projects/Synthesis%20of%20Insight%20Reports_MDT%202021_2.pdf

- **Wessex AHSN Healthy Ageing Community Frailty Audit Evaluation –** The project was initiated as a result of findings from this audit
  https://wessexahsn.org.uk/img/projects/06052020%20Evaluation%20Report%20Wessex%20Community%20Frailty%20Audit%202020%20Publication-1600157256.pdf